The Concerns and Interests of Expectant and New Parents: Assessing Learning Needs

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ABSTRACT

Antenatal education is an important component of antenatal care in the developed world, but research indicates that it may not be meeting consumer needs. This article provides an overview of a needs assessment that aimed to determine the concerns and interests of expectant and new parents and how they prefer to learn during the periods of pregnancy and the early weeks of parenthood. The findings could be used to develop an innovative approach to antenatal education in order to prepare expectant and new parents for the birth experience and the early weeks of parenthood. The current study's results identified that expectant and new parents' concerns and interests during pregnancy, childbirth, and new parenting fall within five interrelated conceptual areas: 1) perceiving achievement or failure; 2) taking on ''risk''; 3) riding an emotional ''roller coaster'' of joy, anxiety, and uncertainty; 4) needing to ''know. . .what is normal''; and 5) needing help to ''perform well.''

Journal of Perinatal Education, *15*(4), 18–27, doi: 10.1624/105812406X151385
Keywords: expectant parents, new parents, childbirth education

Antenatal education is a health-promotion activity that has the potential to influence the heath and well-being of not only the couples who attend, but also their children. In the past, women traditionally prepared for and learned about childrearing through wisdom gained from their extended families and their community. Today, many women do not live in the same area as their immediate family, often work until close to the birth, and come from nuclear families themselves. They also face financial, social, environmental, and political challenges different from the ones experienced by their forebears (Gilding, 2001). Antenatal education has not kept pace with many of these changes.

A review of the literature demonstrates that many antenatal education programs have not been informed by adult learning or other theory. Indeed, some classes are merely an orientation to the birthing center's policies and procedures. Four areas of criticism have been identified:

1. Program content is not based on the needs of program participants (Donovan, 1995; Hillan, 1992; Lee & Shorten, 1998; McKay & Yager-Smith, 1993; Nolan & Hicks, 1997)
2. Content does not match objectives, if they exist (Health Department Victoria, 1990; O'Meara, 1993b).

3. Poor consideration is often given to clients' existing knowledge (Freda, Andersen, Damus, & Merkatz, 1993; Health Department Victoria, 1990).
4. Teaching styles are generally not learner-centred (Nolan, 1998; O'Meara, 1993a; Svensson & Handfield, 2001).

A needs assessment was conducted to inform the development of a new education program provided in a hospital setting. The aim was to explore the concerns and interests of first-time expectant and new parents and to describe the changing nature of these concerns and interests during the childbearing year. It also aimed to ascertain learning processes that best suited parents and to plan antenatal education based on the findings.

METHOD

A longitudinal, multiple-source, multiple-methods design was used. The multiple methods allowed identification of a range of issues and their frequency and importance. The sources of information were first-time expectant and new parents, primary maternity-care providers of these parents, and antenatal education program documentation from three maternity hospitals of comparable size to the two hospitals involved in the study. The data collection methods were repeated in-depth interviews, focus groups, participant observation, surveys, and a review of program documentation. Only data collected from first-time parents are described here.

Ethics approval was obtained from hospital and university ethics committees prior to commencement of the current research. Informed, written consent was obtained from all participants.

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Sample

A total of 205 women and their partners were involved in the research. The women were all employed, educated, and of Australian or English descent. Their ages ranged from 26 to 34 years. A study limitation is that findings are not generalizable to women who are younger, are less educated, or belong to other nationalities. The women in the current study were representative of the majority of women attending the hospitals. Their partners were male, employed, educated, and ranged in age from 28 to 36 years. The numbers of participants, time of data collection, and method of data collection are listed in the Table.

Information about services and their use is often collected using multiple sources. For further discusson on the use of multiple sources, log on to www.biostat.harvard.edu/multinform/background.htm

Setting

Two large, metropolitan, referral hospitals in Sydney, Australia, were selected for the study. The departments, services, annual birth rate, and antenatal education programs of both hospitals were similar.

Data Collection Methods

Interviews. Repeated, in-depth interviews were conducted over a 12-month period with a small sample of expectant and new parents who attended

TABLE
Data-Collection Methods and Samples of Expectant and New Parents

Data-Collection Method	Time Data Collected	Sample
Repeated, in-depth interviews	• Early weeks (<12 weeks) • Middle weeks (12–28 weeks) • Final weeks (28–40 weeks) • Postbirth (8 weeks after birth)	• 9 women and their partners • Cohort followed from early pregnancy to early weeks at home
Focus groups	• Middle weeks (12–28 weeks) • Final weeks (28–40 weeks) • Postbirth (8 weeks after birth)	• 15 women and their partners • 16 women and their partners • 15 women and their partners • Different samples used at each period
Participant observation of antenatal education sessions	• Final weeks (28–40 weeks)	• 50 couples
Surveys	• Middle weeks (12–28 weeks) • Final weeks (28–40 weeks) • Postbirth (8 weeks after birth)	• 52 women and their partners • 46 women and their partners • 48 women and their partners • Different samples used at each period
Total number of participants		**205 women and their partners**

the two participating hospitals. In-depth interviews were deemed the optimal method by which the richness, depth, and dynamic nature of the participants' state of mind, interests, concerns, and preferred learning processes could be obtained during the childbearing year. The researcher, a competent and experienced interviewer, conducted the repeated, in-depth interviews.

To obtain a sample as early in the childbearing year as possible, the researcher contacted general practitioners in the local community and advertised in the community newspaper. These methods produced a convenience sample of 9 expectant parents having their first baby in the research hospitals. The small sample size for the repeated, in-depth interviews was deemed to be sufficient because of triangulation with focus-group data from a similar sample during the middle of pregnancy and later months. Nevertheless, data saturation, as described by Strauss and Corbin (1998), was reached with no new issues, themes, or concerns emerging after the completion of nine interviews at each time period. An open-ended, unstructured questioning process was used (e.g., "What are your interests at this time?" and "What are your concerns at this time?"), with probing used to obtain more detail, if necessary.

For more information on data saturation and variability, read "How Many Interviews are Enough? An Experiment with Data Saturation and Variability," which is available on-line (http://fmx.sagepub.com/cgi/content/abstract/18/1/59).

The parents were interviewed together, rather than separately. Previous exploratory research by this researcher had demonstrated that, when male and female parents were given equal time to provide their own response, they were able to identify similarities and differences between their issues, interests, concerns, and needs. This, in itself, was useful to observe. Time was allocated at the end of each interview for the women and their partners to ask questions and for the researcher to summarise the discussion. The formality of the interviews decreased as trust between the researcher and expectant parents developed.

All interviews were audiotaped, with the permission of the participants. The researcher kept field notes recording nonverbal actions and reactions that occurred during each interview. The participants' salient expressions were briefly recorded in these notes at the completion of the interview.

Focus Groups. Focus groups, both pre- and post-birth, were conducted to obtain data from a larger sample of expectant and new parents receiving antenatal care at the two hospitals. The group dynamics built further on the experiences and ideas identified in the interviews. An understanding of similarities and differences between individuals in groups was also obtained. Participants' insights, comments, and questions were valuable, identifying interests, concerns, preferred learning processes, and education strategies that the expectant and new parents would prefer. Questions and prompts used with focus groups were similar to those applied in the interviews. An experienced group facilitator moderated the focus groups.

Six focus groups were conducted (see the Table). No focus groups were conducted early in pregnancy because the participants had not yet made contact with the hospitals, and it was difficult to recruit numbers of couples at this stage of pregnancy. Convenience samples of expectant and new parents were recruited from antenatal attendees for two focus groups in each time period (i.e., mid-pregnancy, late-pregnancy, and after the birth).

The focus groups were conducted with both parents and in participating hospitals in meeting rooms used for antenatal education. The groups were approximately 1½ hours in duration and held in the evening, with refreshments provided. Participants completed a consent form at the beginning of the focus group. The groups were audiotaped with the permission of the participants. An independent observer was present during each group. The researcher and observer kept field notes recording nonverbal actions and reactions that occurred during each focus group.

The researchers transcribed the tapes of each session prior to commencement of the next focus group. The synchronisation of focus groups with in-depth interview transcriptions allowed checking of the data collected from interview participants. The themes extracted from the data were similar in each time period; for example, women in particular were interested in breastfeeding during the middle weeks of pregnancy. Additionally, information provided by focus-group members and follow-up of important issues with other participants amplified the data.

Surveys. Three surveys were also distributed to convenience samples of expectant and new parents who attended the antenatal education programs at the hospitals:

- Survey 1 was distributed with the participants' program booking confirmation letter and returned by post.

- Survey 2 was distributed and completed by women during the final session of the program.
- Survey 3 was distributed approximately 6 weeks after the birth of the baby.

DATA ANALYSIS

Qualitative data from interviews, focus groups, and surveys were categorised according to the source and method used to collect it. The researcher transcribed all audiotapes, verbatim. Text from transcriptions of the parents' interviews and focus groups was examined for recurring themes, with significant words and phrases highlighted. The words and phrases were then examined more closely for related patterns and the development of subthemes. Through a card-index process, the themes and subthemes were allocated a code, and combinations of codes were retrieved and cross-linked. An independent researcher who analyzed the data derived categories similar to those in the researcher's analysis.

RESULTS

The study participants' insights that related to preparing for childbirth and parenting were categorised into three areas:

1. the concerns and interests of first-time expectant and new parents;
2. how parents prepare for childbirth; and
3. the parents' own ideas for improving antenatal education to meet their needs.

This article presents the concerns and interests of expectant and new parents and how they prepared for childbirth and parenting.[1]

CONCERNS AND INTERESTS OF EXPECTANT AND NEW PARENTS

The concerns and interests of the expectant and new parents during pregnancy, childbirth, and new parenting were divided into five, interrelated, conceptual areas:

1. perceiving achievement or failure;
2. taking on "risk";
3. riding an emotional "roller coaster" of joy, anxiety, and uncertainty;
4. needing to "know. . .what is normal"; and
5. needing help to "perform well."

Pregnancy, Childbirth, and New Parenting as "Achievements"

Early in the pregnancy, the couples responded with exclamations such as "It's positive!" "We're going to have a baby!" "I can't believe it!" "We've succeeded!" and "Wow, our life will never be the same!"[2] These words—accompanied by smiles and physical closeness such as hugging—implied that having a baby brought excitement and a sense of an achievement for many of the expectant parents during early pregnancy. Having a baby was portrayed as a "significant step" in their life as an adult. Among many couples choosing to control their reproductive processes, this "step," for some, was timed in a "window of opportunity" to suit their life plans with "little margin for error" (Diane: 7 weeks).

The notion that having a baby was an achievement recurred throughout the year and was expressed in different ways as pregnancy progressed. The couples used metaphors to describe their "journey." The following comment from Sarah (24 weeks) captured the essence of their ideas:

> *It's rather like steps up a ladder. Every week, there is something to step up to as we head to our ultimate goal—our baby.*

Pregnancy was seen as a series of "milestones," as described in "books and on the Internet." The couples felt they had to reach these milestones, in which their progress could be measured by themselves, family, friends, and indeed "lots of people." It appeared the couples thought that "success" or "failure" to meet the milestones affected how they would be perceived as parents.

Many participants described "reaching the 13th week" as "a turning point in the pregnancy" because they emerged from the "high-risk time" for miscarriage and the woman's growing uterus began to become visible. The "unveiling" of their pregnancy meant they were "finally" able to share their

[1] The expectant and new parents' ideas for improving antenatal education and how their ideas and needs can be incorporated into the development of antenatal programs are presented elsewhere (Svensson, 1999).

[2] In the presentation of results, the actual words used by participants are retained and identified by quotation marks and, in some instances, by italics. Longer comments and questions by participants are identified by parentheses enclosing a pseudonym and a number that represents the weeks in pregnancy the participants were in at the time (e.g., Diane: 8 weeks). The code "FG" identifies data collected from focus groups.

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achievement with others. However, the "feeling of uncertainty about our baby," particularly among the men, was not reduced until after the "screening ultrasound" at approximately 18 weeks.

The birth of the baby (irrespective of the length of labour), the amount of pain experienced, and whether their expectations were met were significant milestones and cherished by all the participants. The couples' overt expression of excitement weakened, however, when they described the challenges of the early weeks at home with their baby.

Concurrent with the sense of pregnancy, childbirth, and new parenting being classified as achievements, the couples conveyed varying levels of concern and self-confidence. The amount of experience the expectant parents had with the children of family and friends appeared to influence these levels. A need to feel "more in control" appeared to be another factor that influenced their level of concern.

Taking on "Risk"

Both women and men perceived pregnancy, childbirth, and "becoming a mum and a dad" as "risky." They identified how, "around the time" they became pregnant, they had often "mulled over" their lifestyle behaviours such as their amount of exercise, food, medication, and their alcohol intake, as well as their work and home environments, in order to maximise their chance of having a healthy baby.

The participants' self-monitoring, both retrospective and prospective, intensified after the pregnancy was confirmed and continued throughout the year. They expressed an ongoing need to "check" details so they "didn't get it wrong (e.g., checking the "dose," timing, and method of administration of substances or factors known to have an adverse effect on the growth and development of their baby). Family, friends, colleagues, and "so many others" also monitored their risk-taking behaviour. Indeed, their behaviour contributed to the "good- or bad-parent label" (FG) placed upon them by others.

The couples expressed that having a baby was "risky" for more reasons than those related to health. Many took a deep breath and said, "Wow!" as they discussed a range of psychosocial, financial, and employment responsibilities and expectations associated with being a parent. They used expressions such as "we'll lose our spontaneity," "we'll lose our independence," "our income will be much less," and "we'll have to be more responsible." As Sue (7 weeks) said:

> *It seems that, by becoming a mum, you lose your position and status at work. No one [colleagues] seems to contact new mums. . . . I'm really scared of being alone.*

Women and men differed in their priorities and concerns when interviewed at approximately 24 weeks of pregnancy. The women had become focussed around a concern of "becoming a mum"; indeed, they expressed a distinct concern about breastfeeding at this time. By comparison, the men appeared to become "very concerned about labour" because they realised they did not have a "role model to follow" (Jim: 25 weeks). They had not, however, shared their labour and birth concerns with family or friends because some tended to "ridicule" them. Many of the men were also unable to attend antenatal check ups "because of work"; thus, both professional and family support were minimised for expectant fathers during early- and mid-pregnancy.

During the final weeks of pregnancy, some discrepancy remained between the women's and the men's concerns and needs. Women expressed concern about feeling isolated in the early weeks at home with their baby. The men continued to express concerns about labour, adding worries about how to care for their baby and how their relationship with their partner would change after the birth.

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Riding an Emotional "Roller Coaster"

Entering an unknown world was exciting; however, the couples also described their experiences as "challenging and strange" and similar to riding

a ''roller coaster.'' The women described their ''moodiness,'' ''irritability,'' and ''being tired and emotional' in the early weeks of pregnancy as uncharacteristic of their ''stable nature.'' They expressed concern that their ''secret'' (their newly diagnosed pregnancy) would be revealed by their unusual emotional lability.

During the year, the women talked about their ''highs'' and ''lows.'' Many hated becoming ''public property,'' which they felt pregnancy had made them become, and did not like the lack of emotional sensitivity shown by their doctor or midwife. It appeared that their concern about how they and others perceived the women and men as parents and applied labels such as ''success,'' ''failure,'' and ''risk taker'' contributed to their roller-coaster experience. Some found the whole roller-coaster ride ''really, really hard,'' and it appeared to shatter their ''confidence in anything'' (FG). The men's feelings were closely tied to those of their partners. However, the men's concerns about financial responsibility and where they were living came to the fore in the early weeks of pregnancy.

Needing to Know —"What Is Normal?"

The question ''what is normal?'' pervaded the interviews and discussions during the year. It appeared to be influenced by the participants' vision of having a baby being an achievement and a progression through recognised milestones. The couples expressed a constant need to ''check'' their progress, and they wondered, ''What can we expect in the next few weeks?'' (FG), to be prepared for forthcoming events during the year. Their concerns stimulated a ''thirst'' for books and anything that provided a ''timeline of the milestones.'' Some women revealed mistrust in their body and the pregnancy processes, which created a dependence on a ''midwife,'' ''doctor,'' or child- and family-health ''nurse.'' As Annette (24 weeks) portrayed:

> *It's good that I see my midwife regularly because I can confirm that the books I'm reading and how I feel [are] correct.*

The men appeared less interested than the women in measuring the physical and emotional milestones their partner experienced during the pregnancy because ''the doc [doctor] can do that'' (Paul: 24 weeks). Instead, they focussed their interest on ''the growth and development of our baby'' and on what to expect during labour. After the birth, the interests of both the women and men centred on the growth and development of their baby.

During the childbearing year, the participants' need to know ''what is normal'' also translated into ''what is normal practice?'' During the early weeks of pregnancy, the participants asked specific questions related to ''providers of care,'' ''health insurance,'' and ''tests women have.'' They were also interested in general parenting responsibilities because they ''realised we are going to be parents'' (Diane: 7 weeks).

By the middle weeks of pregnancy, the couples' ''normal-practice'' interest appeared to become focussed on specific services and parenting responsibilities. Women were interested in breastfeeding, and men asked questions about labour and birth. As the birth of their baby became ''imminent,'' both the women and the men displayed an interest in the normal behaviours and practices of themselves and others ''during labour and in the first few days of our baby's life.'' The role of available community services was of ''particular interest after the birth.''

Needing Help to "Perform Well"

Needing help to ''perform well'' appeared to be influenced by the participants' belief that having a baby was a ''risk'' and that others would monitor their risk-taking behaviour and apply a label such as ''good'' or ''bad.'' The couples expressed a continual ''need to know what are the best things to do.'' Their questions dovetailed those of ''what is normal practice?'' and, as the year progressed, changed from general parenting issues (e.g., how they would discipline their child) to more specific and practical tasks such as how to bathe a baby.

The men wanted to know ''precisely'' what they had to do to ''get it right.'' *It* referred to many factors known to enhance or adversely affect the growth and development of their baby. There was a sense that, by sequentially monitoring the presence of and, when necessary, acting upon these factors, the men were fulfilling their ''role to help'' their baby.

The participants asked questions that were diverse and not related solely to what they were feeling at the time. For example, even when the women were pregnant at 7 weeks, they wondered what would happen to their body after birth. The women and men asked idiosyncratic and individual questions relating to their own fears and concerns; however, some commonalities existed as well.

Many described the overabundance of information as being "overwhelming and confusing."

HOW EXPECTANT AND NEW PARENTS PREPARE FOR CHILDBIRTH AND PARENTHOOD

Preparation was the second category of the current study. During the childbearing year, the participants prepared themselves for pregnancy, childbirth, and parenting by talking to others, watching others, seeking support, and learning from their own experience. Each of these themes is described below.

Talking to Others

The expectant and new parents identified "talking to others" as an "important way to address our concerns and interests" (FG). It appeared the probability of their having "only one or two children" was a "driving force" behind their proactive and, at times, reactive "search for answers to our many questions." The participants had access to "truckloads of information"; however, many described the overabundance of information as being "overwhelming and confusing," which made some participants feel anxious. They wanted information that was "current," "correct," "reliable," and provided by a "trustworthy" and "approachable" person (FG).

During the early weeks of pregnancy, the participants' self-enforced "veil of secrecy" (Bridget: 8 weeks) created a "really anxious time." They felt limited in who they could confide with. Many, like Peter (8 weeks), were "silently searching" for a health professional that would "go through what was happening and check all [physical and emotional changes] was normal." For many participants, the situation was aggravated by the fact that they did not access their general practitioner because "well, he is always so busy" or they did not have one. Many declared that not seeing an obstetrician or midwife until after the 13th week of pregnancy was "ridiculous" because it was an anxious time. However, after "the word was out that we were having a baby," the participants described receiving support from many people, including unsolicited support. As Annette (24 weeks) said, "We got ideas from *everyone*. . ., even people in the street stop to tell me what to do." The couples' underlying concerns of needing to "get it right" and "perform well" created mistrust in "unsolicited advice."

Watching Others

As they "ventured into a world we don't know," the participants described how their "eyes were wide open watching others," and "they felt like absorbent sponges lapping it [what their friends were doing] all up." It appeared the responsibilities associated with becoming a mum and a dad meant the expectant and new parents were reluctant to perform actions by trial and error. The skills required when having a baby had to be observed and learned.

Seeking Support

The parents differed in the support they sought, depending on their level of interest or concern and when it occurred. Some said they "sought comfort" from their mother early in the pregnancy because "at least she was a woman who understood." However, seeking support appeared to create a dilemma for some participants. For example, the more their mothers became involved, the more likely the mothers were to voice expectations and ideas that may not have been in agreement with the participants' own outlook. "Joining an ongoing group" (e.g., yoga or exercise classes), where there was a "professional who could answer my questions' (Bridget: 23 weeks) and peers the couples learned to trust, was identified as a "really good way to get info and support" (FG). As Jim (9 weeks) said, 'If she [the expectant mother] gets the answers she wants, she'll chill out and we'll all feel a lot better."

Antenatal classes—the one type of group support that all participants had experienced—were described as "essential for women and their partners" (FG). "Meeting and getting to know others on this journey" and having the "opportunity to clarify information we had read and heard with an educator" were reasons why many participants chose to attend antenatal classes (FG). Attendees appeared much more in control of that which they wanted from classes than professionals would expect.

However, many of the women and men criticised the content of antenatal classes—in particular, the lack of parenting information. The following comments illustrated their concern:

> *I have been amazed how little the emphasis on the baby has been. Well, the birth is 24 hours and yet the baby seems such a tag-on. I would have been*

happy to do a 6-week program on parenting. I have always wanted to have children, so I am interested in learning about children. I am not a reader—the self-discipline of enrolling in a program is what I need. (Adam: 35 weeks)

Parenting. . .there wasn't any. We could have done with half of the program on parenting and the baby. We repeated so much information on the birth it was crazy. (Peter: 35 weeks)

Learning From Experience

Although many participants did not want to use trial and error (versus gaining knowledge) because of the risks involved, the personal life experiences of the women and men appeared to contribute to coping and adjustment skills during pregnancy and after birth. Indeed, couples who had minimal personal experience with pregnancy, birth, and being a parent—even if they actively sought answers and advice from professionals, books, the Internet, and friends—said they did not realise how ''isolated and lonely'' they could feel.

The expectant and new parents reported that experiential learning was not a common type of learning style in the antenatal programs they attended. However, when experiential learning was experienced in class, the participants rated it as a preferred learning strategy.

DISCUSSION

Findings from the current study identified that, for women and men, social support is a more important component of ante- and postnatal care and education than most professionally run courses would acknowledge. The importance of social support is often deemphasised. Indeed, the current study's researchers argue, as does Enkin (1990), that women attend antenatal education classes for reasons other than learning how to have a shorter labour and to avoid medical interventions. Women wish to become informed, obtain advice, have their questions answered, reduce anxiety, and meet other expectant parents (Enkin, 1990).

Until the last decade, antenatal education focused on pregnancy, labour, and childbirth, with very little time given to infant care and early parenting. Although the parenting component has been strengthened more recently, the results of the current needs assessment suggest that further changes are required. This finding has also been identified in other research (Barclay, Everitt, Rogan, Schmied, & Wyllie, 1997; Nichols, 1995; Schneider, 2001). Women and men in the present study were able to articulate the content and process of the antenatal education they preferred. This finding challenges health professionals' long-standing belief that expectant women and men do not know what they want until the baby is born. Indeed, the richness of the data obtained throughout the in-depth interviews and focus groups leads one to conclude that programs should be developed proactively through the use of these methodologies, rather than reactively through program-evaluation surveys traditionally used by health professionals.

The expectant and new parents in the present study rarely used words such as ''taught'' and ''classes,'' preferring to be actively involved in their learning. The activities they preferred, which are outlined elsewhere (Svensson, 1999), were actions recommended in adult-learning literature (Killen, 1998). As Nolan and Hicks (1997) state, ''While teachers often fear frightening women with graphic accounts of what giving birth may involve and the difficulties of early parenting, women themselves are keen to have the full story warts and all'' (p. 180). Indeed, as McKay, Barrows, and Roberts (1990) found, women expressed feelings of betrayal when the sensations they experienced in second-stage labour were infinitely stronger and more urgent than they had anticipated and learned about from the information they received during antenatal education.

The language used by this study's expectant and new parents during the childbearing year described a journey that demanded responsibilities for which they had to be prepared, with some couples requiring more preparation than others. Throughout the childbearing year and in their effort to be prepared, participants actively sought information, help, and support on parenting issues. Many were surprised by the lack of opportunities for formal education until near the end of pregnancy. The adherence to a strict, gestational timeline of information provided by professionals also amazed and frustrated the parents. Indeed, anxiety and isolation appeared to be outcomes of the deficiency of information and its strict timeline, which seemed

When experiential learning was experienced in class, the participants rated it as a preferred learning strategy.

to affect the participants' confidence in being a mum and a dad.

An examination of the participants' questions and comments revealed that the journey of the women differed slightly from that of the men after the early weeks of pregnancy. The majority of the women appeared to connect with, and be interested in, their baby by the 13th week; whereas, the men experienced a delay in connection with their baby until the ultrasound at approximately the 18th week. Seeing the baby on the screen provided a sense of reality for the men, a phenomenon that has been noted in previous research (Draper, 2002). After this event, the men became far more interested in the growth and development of the foetus and their infant and in the physiological processes of labour, as the year progressed. The women, however, appeared keen to learn practical tips about baby care and breastfeeding. Men, like the women, appeared frustrated and anxious when their information needs were not met, which reinforced previous researchers' recommendations that men have specific needs and should be integrated into antenatal education (Friedewald, Fletcher, & Fairbairn, 2005; Friedewald & Newing, 2006; Premberg & Lundgren, 2006; Schott, 2002; Somers-Smith, 1999).

CONCLUSION

The present study demonstrated that expectant women and men have idiosyncratic and different concerns during the various stages of pregnancy. Additionally, first-time expectant and new parents need opportunities to discuss and learn from peers and professionals so they can be better parents and know what is normal. Social needs gained from structured and unstructured formal education sessions, such as antenatal education, are valuable for social support and confidence. Content areas of breastfeeding and parenting could be improved and provided earlier in pregnancy.

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Lamaze Specialty Workshop 2006 - 2007 Schedule

Breastfeeding Support Specialist Workshop	***Labor Support Skills for Nurses Workshop (1-Day)***	***Mission Possible Workshop (1-Day)***	***Teen Specialist Workshop***
18 Lamaze Contact Hours 18 Nursing Contact Hours 18 IBLCE L-CERPs 15 Level III CDR CPEUs NOTE: Lamaze International has applied for 17 ICEA contact hours.	9 Lamaze Contact Hours 9 Nursing Contact Hours	7.4 Lamaze Contact Hours 7.4 Nursing Contact Hours 0.6 IBLCE L-CERPs 6.8 IBLCE R-CERPs NOTE: Lamaze International has applied for 7 ICEA contact hours.	18 Lamaze Contact Hours 18 Nursing Contact Hours NOTE: Lamaze International has applied for 16 ICEA contact hours.
	February 28 or March 1, 2007 St. Louis, MO	**December 8, 2006* Pompton Plains, NJ**	**January 27 - 28, 2007* Marietta, GA**

**** Public Lamaze Specialty Workshops:*** Please visit the Lamaze Web site at ***www.lamaze.org*** to register for public Lamaze workshops. For registration details regarding all other workshops, please visit the Lamaze Web site or call 800-368-4404.